An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2019-0281
Sector:	Insurance
Product / Service:	Travel
Conduct(s) complained of:	Rejection of claim - cancellation Dissatisfaction with customer service
Outcome:	Substantially upheld

LEGALLY BINDING DECISION
OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

Background

The Complainants held a travel insurance policy with the Provider. The Complainants were due to depart on a cruise from the USA on **8 October 2017**. Prior to the departure of the cruise the First Complainant became ill and on the advice of a retired nurse returned to Ireland with the Second Complainant on **5 October 2017**. Within hours of arriving in Ireland, the First Complainant attended his GP who advised him not to embark on the cruise. The Complainants then cancelled their cruise. The First Complainant made a claim under the policy in respect of the cancelled cruise. The Provider declined the claim on the basis of the First Complainant's failure to comply with the terms contained in the policy.

The Complainants' Case

The First Complainant states that this complaint relates to *"… a cancelled cruise due to sudden ill health …"* The First Complainant states that his ill health arose while he was in the USA and prior to the departure of a cruise with the Second Complainant. Referring to the Provider's Final Response letter, the First Complainant states that the Provider's decision appears to be based on the fact that he did not notify the Provider of his intended claim until he returned to Ireland on **5 October 2017**, the day after he became ill and had consulted with his GP in Ireland. The First Complainant states that *"[t]here is an assumption that, had I contacted the [Provider] the previous day, the day my symptoms appeared, [the*

Provider] would have directed me to a medical facility in the US who would have declared that it would not have been medically necessary to cancel my cruise."

The First Complainant states that all medical advice beginning with the retired nurse practitioner who advised him at the onset of his symptoms in the USA on **4 October 2017** to his GP 24 hours later and through to his urologist, confirmed that he made the correct decision to return to Ireland and not embark on the cruise.

The First Complainant acknowledges that he did not contact the Provider until he returned to Ireland and had a consultation with his GP. The First Complainant *"… made that decision knowing I would be at my GP's surgery within hours of getting to a facility in the US and would therefore have medical care not just for treatment of the symptoms … but to investigate the cause of the illness. Medically, I made the most responsible decision for me at the time."*

The First Complainant states that he was symptom free for 4 days by **12 October 2017** and not 5 days as stated in the Final Response letter. The First Complainant points out that this is a significant correction as he was still passing blood in his urine the day the cruise ship departed on **8 October 2017**.

The First Complainant states that the Provider offered both Complainants €500 in its Final Response letter. The First Complainant states that *"No direct offer of E500 was made to us in that letter."* The Second Complainant was in contact with the Provider on **11**, **13** and **14 June 2017** and was told that *"… this E500 was an offer and the claims section would be in touch."* The First Complainant states that they received an unsigned letter in the post on **15 June 2017** informing the Complainants that the €500 would be lodged directly into their account. The First Complainant states *"We did not request or agree to this money entering our account. We understood one reached a settlement between the two parties prior to any monies being lodged and we have <u>not</u> reached a settlement with [the Provider]."*

With respect to the Provider's appeals process the First Complainant states that *"… due process, transparency and fairness were very much in question."*

In resolution of their claim, the Complainants want *"… a financial refund of the basic cost of the cruise …"* of €6,204.

<u>The Provider's Case</u>

The Provider submits that the Complainants did not comply with section 9 of the policy and has quoted this section in its submissions to this Office. The Provider *"acknowledges and respects"* the Complainants' comments that they believed they made the best medical decision at the time. However, the Provider submits that based on the information presented it is difficult to determine that the Complainants acted reasonably and there is no evidence to demonstrate that they mitigated their loss by taking the action they did.

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The Provider states that the policy document states:

> *"You must exercise reasonable care for the supervision and safety of both You and Your property. You must take all reasonable steps to avoid or minimise any claim. You must act as if You are not insured.*
>
> *You must obtain a medical certificate from the Medical Practitioner in attendance and Our prior approval to confirm the necessity to return."*

The Provider states that it would be reasonable to expect that the Complainants would have sought medical attention and a relevant diagnosis in the country they were in at the time. It is unreasonable to expect the policy to cover a decision to curtail and cancel the impending cruise without seeking an adequate medical diagnosis and supply supporting documentation to substantiate the need to curtail and cancel the cruise.

The Provider states that the decision to decline the claim is not based on the fact that the Complainants did not notify it of their intention to return to Ireland. The decision to decline the claim is based on the fact that the decision to curtail and cancel the cruise was done before it was confirmed or deemed medically necessary to curtail and was not supported by any effort to attend a medical practitioner in the country the Complainants were visiting. The Provider states that in addition to this, *"… there was also the support of the medical emergency who could be contacted before any decision to curtail/cancel which unfortunately the complainants did not utilise."*

The Provider states that the level of cover under the policy is not supported by the Complainants' decision to return home and cancel the cruise prior to any medical consultation. The medical report received with the claim form gave an indication that prior to the cruise departure date the First Complainant was symptom free thus removing the need to cancel due to illness.

In respect of whether or not the First Complainant was symptom free for 4 or 5 days by **12 October 2017** the Provider states that the pertinent detail is in the fact that he was *"… symptom free … for a period of time before the cruise embarked."* The Provider states that had the Complainants sought a medical consultation in the country they were in and received the relevant treatment as administered by the GP, the First Complainant would have been symptom free for a period of time prior to the cruise embarking and therefore there would have been no need to curtail the cruise. The Provider states that it acknowledges that the Complainants may not have been aware of this when they took the decision to travel home and that the First Complainant may have still been feeling unwell and did not wish to embark on the cruise. It states that the policy does not cover any disinclination to travel.

The Provider states that it does not discount that the First Complainant had further tests and surgery subsequent to his initial symptoms and illness however, the appeal process did not require information pertaining to any subsequent treatment.
The pertinent questions were those necessary to establish whether it was medically necessary to curtail the trip and cancel the cruise. The Provider states that on review of the

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further information provided by the First Complainant's GP the decision to decline the claim was maintained as it was not clear that it was medically necessary to curtail and cancel at the time of the initial illness and the fact that the First Complainant was symptom free for days prior to the cruise departure.

In terms of the Provider's handling of the Complainants' complaint the Provider states that on **11 December 2017** its assessor informed the Complainants that their claim was going to be declined and *"[d]uring this call the assessor outlined to the complainant to appeal the decision once the formal declinature letter was received."* The Provider states that further documentation was received and a different assessor handled the appeal. The Provider states that it called the Complainants on **11 January 2018** to advise them as to the progress of their appeal and that further documentation was required from their GP. The Provider states that the Complainants were away until **23 January 2018** and further correspondence issued to the Complainants on **26 January 2018**. The Provider states that the decision to decline the claim was maintained and a letter in respect of this issued to the Complainants on **14 February 2018**. The Provider acknowledges that due to an error the second declinature response contained the name of the original assessor however, the Complainants' appeal was reviewed by a different assessor.

The Complaints for Adjudication

The complaints for adjudication are that the Provider:

- wrongfully and/or unreasonably declined the Complainants' claim; and
- did not handle the Complainants' claim in an appropriate manner.

Decision

During the investigation of this complaint by this Office, the Provider was requested to supply its written response to the complaint and to supply all relevant documents and information. The Provider responded in writing to the complaint and supplied a number of items in evidence. The Complainants were given the opportunity to see the Provider's response and the evidence supplied by the Provider. A full exchange of documentation and evidence took place between the parties.

In arriving at my Legally Binding Decision I have carefully considered the evidence and submissions put forward by the parties to the complaint.

Having reviewed and considered the submissions made by the parties to this complaint, I am satisfied that the submissions and evidence furnished did not disclose a conflict of fact such as would require the holding of an Oral Hearing to resolve any such conflict.

I am also satisfied that the submissions and evidence furnished were sufficient to enable a Legally Binding Decision to be made in this complaint without the necessity for holding an Oral Hearing.

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A Preliminary Decision was issued to the parties 14 August 2019, outlining the preliminary determination of this office in relation to the complaint. The parties were advised on that date, that certain limited submissions could then be made within a period of 15 working days, and in the absence of such submissions from either or both of the parties, within that period, a Legally Binding Decision would be issued to the parties, on the same terms as the Preliminary Decision, in order to conclude the matter.

In the absence of additional submissions from the parties, within the period permitted, I set out below my final determination.

It is important to emphasise that, for the purpose of assessing this complaint, it is not the role of this Office to comment on or form an opinion as to the nature or severity of the Complainant's illness or condition. It is the duty of this Office to establish whether, on the basis of an objective assessment, the Provider has adequately assessed the Complainant's claim and whether it was reasonably entitled to arrive at the decision it did following its assessment of the claim.

The Policy

The Provider has furnished a copy of its terms and conditions. I have reviewed this document and I note the follows provisions:

> *"**What do I do if I need emergency medical treatment abroad?***
>
> ***[Provider] Healthcare Hospital Plan Members***
>
> *If You are a [Provider] Hospital Plan member please call the Assist number relevant to your location.*
>
> ***USA & Canada (Toll Free)*** ***Tel:*** *[…]"*

In the *Meaning of words* section the policy states:

> *"**Curtailment:** Abandonment of a planned Trip, after commencement of the outward journey, by return Home earlier than on the scheduled return date."*

The policy also states under the section *Important difference in Terms & Conditions*:

> *"**Reasonable Care:** You need to take all reasonable care to protect Yourself and Your property, as You would if You were not insured."*

Section 9 of the policy deals with cancellation, curtailment and trip interruption. The relevant parts of section 9 state as follows:

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*"**Curtailment** cover applies if You are forced to cut short a Trip You have commenced because of one of the following changes in circumstances which is beyond Your control and You were unaware at the time You commended Your Trip.*

Changes in Circumstances

- *Unforeseen illness, injury or death of You or any person with whom You have arranged to travel or stay during the Trip, or upon whom Your Trip depended.*

…

Your cancellation or curtailment must be necessary and unavoidable in order for You to claim.

…

Special conditions relating to claim in this section

You must obtain a medical certificate from the Medical Practitioner in attendance and Our prior approval to confirm the necessity to return Home prior to the scheduled return date of the Trip in the event of unforeseen illness or injury.

In the event of Curtailment … You must contact Us first and allow Us to make all the necessary travel arrangements. If, at the time of requesting Our assistance in the event of a Curtailment … satisfactory medical evidence is not supplied in order to substantiate that the claim is due to an unforeseen illness, injury or death of You …

*We will make all necessary arrangements at **Your cost** and arrange appropriate reimbursement as soon as the claim has been validated.*

…

Curtailment claims will be calculated from the date of return to Ireland."

In the *General Conditions* section the policy states:

"10. You must exercise reasonable care for the supervision and safety of both You and Your property. You must take all reasonable steps to avoid or minimise any claim. You must act as if You are not insured.
…

31. We will not accept liability for expenses incurred without Our prior knowledge and consent and the Emergency Centre must be contacted when an incident arises that may be the subject of a claim."

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The First Complainant's Claim

The First Complainant completed a curtailment claim form dated **31 October 2017**.

The Provider's curtailment claim form requires a completed medical declaration:

> *"The medical declaration document which forms part of this claim form needs to be completed, signed and stamped by the medical doctor of the patient whose illness necessitated your curtailment."*

The medical declaration was completed by the First Complainant's GP.

The form also requires a letter from the treating doctor abroad and states:

> *"If curtailment was as a result of your medical condition, it is necessary to provide detailed reasons from the treating medical doctor abroad stating why it was medically necessary to curtail/extend your trip."*

The First Complainant submitted a letter dated **17 October 2017** from a retired nurse practitioner with whom he consulted prior to returning to Ireland. This nurse practitioner was staying in the same accommodation as the Complainants while they were in the USA. This letter states:

> *"[The First Complainant] was on holiday in the United States when he fell ill and was advised by myself to return to Ireland for care. The following is a detailed analysis of the medical procedures for diagnosis and treatment of his condition as well as the underlying rationale for returning to Ireland for treatment.*
>
> *…*
>
> *Date of consultation: 4 October 2017*
>
> *…*
>
> *On consulting with [the First Complainant], he noted sudden onset during the night of frequency and urgency of urination followed by bleeding in the urine. I visually was able to see the blood and spoke with [the First Complainant] of his options for care. It should be noted that he was due to go on a cruise in a few days that would last over a week.*
>
> *The normal procedure for this condition would be to see a medical practitioner who would do a physical exam, check the urine for blood, protein and bacteria, check the blood for elevated white blood cells, and initially prescribe an antibiotic. Depending on the patient's condition … hospitalization with an IVP, CAT scan of the kidneys, etc. might be necessary. Should the antibiotics alone work for his condition, it would be 14 days before the urine could be recultured, and he would still need at least a cystoscopy to rule out bladder cancer, interstitial cystitis, or other pathologies. From*

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start to finish this would take at least 3 to 4 weeks – especially since he had no medical provider in the United States.

His initial presentation was also indicative of possible acute pyelonephritis. Because this condition can quickly turn to sepsis and be life threatening, there was no possibility of going on a cruise for over a week.

Upon evaluation of his condition and the probable course of treatment, I advised him to return to Ireland. He was stable the morning I saw him, could be on a flight in hours, and could be seen in Ireland the next day. It was unlikely much could be done here in one day and treatment started in one country and then continued in another would present difficulties of communication and continuity of care that might jeopardize [the First Complainant's] wellbeing."

By letter dated **15 November 2017** the Provider wrote to the First Complainant requesting all medical records in respect of the First Complainant from **1 September 2017**. This request was complied with by the First Complainant by letter dated **1 December 2017**.

Correspondence

By letter dated **18 December 2017** the First Complainant was informed that his claim was declined on the following basis:

"It is noted that had medical attention been sought whilst abroad, it would not have been deemed medically necessary for you to curtail your trip. Therefore, we are, regrettably, unable to allow benefit on this occasion in line with the above terms and conditions."

The First Complainant informed the Provider by letter dated **8 January 2018** that he wished to appeal this decision. The First Complainant also enclosed a letter from his GP dated **8 January 2018**. The First Complainant's GP wrote:

"… As you are aware, he was seen by me on 5/10/17. He returned home from holidays early as he was suffering from symptoms consistent with pyelonephritis and had been systemically unwell. During that consultation [the First Complainant] and I discussed the various management options and we decided on a trial of treating the condition with oral antibiotics.

This agreement was made on the understanding that [the First Complainant] would reattend the practice on 12/10/18 for review and indeed would come in for review before then if his condition deteriorated.

[The First Complainant] attended again on 12/10/18 and had been symptom free for 4 days and not 5 days as stated previously in my earlier correspondence.

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In my opinion, [the First Complainant] made the correct decision to return early from holidays on medical grounds. He may not have responded well to oral antibiotics and may have required intravenous antibiotics. It was not possible to predict with certainty that he would make such a recovery and he needed immediate access to his General Practitioner and hospital services should his condition have deteriorated."

Following this, the Provider sent a letter dated **11 January 2018** to the First Complainant's GP containing a number of questions. The First Complainant's GP responded by letter dated **30 January 2018** which states:

"3) I believe [the First Complainant] was not fit to travel on a cruise as outlined in my previous correspondence. I did not advise him to travel back to Ireland for a consultation here.

4) If [the First Complainant] received the same treatment in America, he would have had a similar outcome. As outlined previously, his prognosis was unclear when he initially consulted me.

5) I think he was right not to travel on the cruise as his prognosis was guarded and he needed better access to medical support."

The Provider informed the First Complainant by letter dated **15 February 2018** that its original decision remained unchanged. In this letter the Provider states:

"It is noted that [the First Complainant's GP] has confirmed that he did not advise you to return back to Ireland for a consultation and had you sought treatment in America your symptoms would have resolved."

The Provider's internal notes in respect of the First Complainant's symptoms dated **28 May 2018** states:

"[…] reviewed in conjunction with the nurses and medical detail provided by member: Discussed case with […] (Nurse). From the medical records the client was feeling very unwell with a temperature and was passing blood. No lab tests were completed – a dip stick test confirmed there was blood in the urine. […] noted he was on aspirin meaning it would not be unusual for the client to have blood in his urine but MR also stats "gross haematuria". The Dr has input that the client had "symptoms consistent with pyelonephritis". In the medical notes from 5.10.17 it has "? Pyelonephritis", i.e. no definite diagnosis.
The client went back to visit the Dr on prescribed antibiotics he would have been symptom free by the time the cruise started on 8.10.17. There is no evidence to suggest therefore it was medically necessary for him to curtail his trip. …"

In the Provider's Final Response letter dated **6 June 2018**, the Provider states on the second page:

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"I am sorry to inform you that following an underwriting review they have not agreed to give your cancellation claim consideration. There has been no evidence to support you mitigated a loss in taking the action you did.

While I acknowledge you were unwell and have subsequently undergone surgery since the initial symptoms, I have been unable to ascertain why you did not make use of the emergency assistance service for advice. The emergency assistance number as per your policy documents could have been used to obtain medical advice and information on where you may be able attend a medical facility or practitioner in the USA.

I refer to your policy documents …

Had you attended a medical facility in the USA and undergone the same treatment as you did at home it is likely you would have had the same outcome and have been symptom free for five days by the 12 October and therefore it would not have been medically necessary to cancel the cruise.

I appreciate you stated you made the most responsible medical decision for you at the time, but instead of taking a more appropriate course of action by attending a medical facility in the USA, you rescheduled flights home to attend your own GP immediately on your arrival home. However in doing this you did not have enough adequate documentation to validate your claim for cancellation.

From a technical review and in line with the policy terms and conditions, your claim was correctly declined as the cancellation of the impending cruise was not supported by the necessary documentation. Given this I therefore cannot uphold your complaint."

Analysis

The Complainants were due to depart on a 14 night cruise on **8 October 2017** from the USA. In the days leading up to the departure date the First Complainant suddenly became ill and following advice from a retired nurse practitioner returned to Ireland with the Second Complainant on **4 October 2017**. The First Complainant attended his GP on **5 October 2017**. The Complainants cancelled their trip following this consultation and as per section 7 of the claim form, this is the date that curtailment of the cruise was recommended. The Complainants submitted a curtailment claim form to the Provider dated **31 October 2017**.

In support of his claim, the First Complainant submitted a letter from the retired nurse practitioner who initially advised him to return to Ireland. On his return to Ireland and following a consultation with his GP, the First Complainant was advised not to embark on the cruise.

The Complainants' decision to return to Ireland was based on the symptoms the First Complainant was experiencing and the medical advice given to the First Complainant from

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a retired nurse. While the Provider disagrees with the Complainants' decision to return to Ireland, I note that the Provider has not challenged the diagnosis of the retired nurse. Furthermore, the Provider states that the Complainants did not contact the emergency contact number.

It is not reasonable or acceptable for the Provider to seek to rely on this aspect of the policy as forming part of its entitlement to decline the claim. Furthermore, I do not consider this to be a requirement of the policy. These contact details are contained on the cover of the policy under the heading *"**What do I do if I need emergency medical treatment abroad?**"* I consider this to be for informational and assistance purposes rather than as contractual pre-conditions to a making a valid claim.

The policy states at section 31 of the *General Conditions* that *"… the Emergency Centre must be contacted when an incident arises that may be the subject of a claim."* The term Emergency Centre is not defined in the policy and neither are any specific contact details given for this centre. I consider section 31 to be distinct and separate from the section headed *"**What do I do if I need emergency medical treatment abroad?**"* Furthermore, the Provider has not sought to rely on or refer to this section of the policy in support of its decision to decline the First Complainant's claim.

In its letter dated **18 December 2017**, the Provider states:

> *"It is noted that had medical attention been sought whilst abroad, it would not have been deemed medically necessary for you to curtail your trip."*

In its Final Response letter the Provider states:

> *"Had you attended a medical facility in the USA and undergone the same treatment as you did at home it is likely you would have had the same outcome and have been symptom free for five days by the 12 October and therefore it would not have been medically necessary to cancel the cruise."*

Furthermore, the Provider states in its submission to this Office that:

> *"It is unreasonable to expect the policy to cover a decision to curtail and cancel the impending cruise without seeking an adequate medical diagnosis and supply supporting documentation to substantiate the need to curtail and cancel the cruise."*

The Provider has not submitted any evidence to support these statements which are completely contrary to the medical evidence submitted by the First Complainant in support of his claim. I note from the Provider's internal notes that the First Complainant's claim was discussed with a nurse practitioner and it was the opinions offered by this individual that informed the Provider's decision to decline the claim.

The Provider has simply focused on whether or not the First Complainant was symptom free at the time the cruise was due to depart. The First Complainant's GP has stated that his condition was more nuanced and complex than simply being symptom free by the departure

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date. There appears to be a lack of appreciation of this on the part of the Provider in its assessment of the claim.

I accept that, based on the medical evidence available to the First Complainant prior to **8 October 2017**, it was medically necessary to curtail the cruise and that the First Complainant supplied appropriate documentation in support of his claim.

I do not accept that the Complainants' failure to obtain the Provider's prior approval before returning to Ireland necessarily entitles it to decline the claim. The policy states:

> *"In the event of Curtailment … You must contact Us first and allow Us to make all the necessary travel arrangements. If, at the time of requesting Our assistance in the event of a Curtailment … satisfactory medical evidence is not supplied in order to substantiate that the claim is due to an unforeseen illness, injury or death of You … We will make all necessary arrangements at **Your cost** and arrange appropriate reimbursement as soon as the claim has been validated."*

This suggests that a claim will be accepted where medical evidence is not available prior to curtailment. Even though the First Complainant had medical evidence to support his decision to return to Ireland, the Provider is arguing that because its approval to confirm the necessity to return was not obtained, the claim was decline. I do not consider this a reasonable approach to adopt.

I do not accept that the Complainants' failure to mitigate their loss is a factor the Provider can rely on in declining the claim, particularly in light of the fact that the claim is in respect of the cost of the cruise itself - no other expenses are being claimed by the Complainants.

I note the Policy Document states:

> "*You must exercise reasonable care for the supervision and safety of both You and Your Property. You must take all reasonable steps to avoid or minimise any claim. You must act as if You are not insured".*

I believe this is exactly what the Complainant did. There is no way of knowing what cost the Complainant would have incurred if he had sought medical assistance in the US. It is important to note that we are now operating with the advantage of hindsight.

The Complainant had no way of knowing what medical procedures or costs he was facing. I believe it is reasonable to assume that if he was not insured, he would have taken the same course of action.

Taking the above matters into consideration I do not accept that it was reasonable for the Provider to decline the claim.

Therefore, I uphold this aspect of the complaint.

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Finally, the second aspect of this complaint relates to the manner in which the Provider handled the Complainants' complaint. Having considered the evidence and submissions of the parties in relation to this aspect of the complaint I do not consider that the Provider handled the Complainants' complaint in an unreasonable or inappropriate manner.

Therefore, I do not uphold this aspect of the complaint.

For the reasons outlined above, I substantially uphold this complaint and direct the Provider to pay a sum of €6,500 in compensation to the Complainants.

Conclusion

My Decision pursuant to ***Section 60(1)*** of the ***Financial Services and Pensions Ombudsman Act 2017***, is that this complaint is substantially upheld, on the grounds prescribed in ***Section 60(2) (b).***

Pursuant to ***Section 60(4) and Section 60 (6)*** of the ***Financial Services and Pensions Ombudsman Act 2017,*** I direct the Respondent Provider to make a compensatory payment to the Complainants in the sum of €6,500, to an account of the Complainants' choosing, within a period of 35 days of the nomination of account details by the Complainants to the Provider.

I also direct that interest is to be paid by the Provider on the said compensatory payment, at the rate referred to in ***Section 22*** of the ***Courts Act 1981***, if the amount is not paid to the said account, within that period.

The Provider is also required to comply with ***Section 60(8)(b)*** of the ***Financial Services and Pensions Ombudsman Act 2017.***

The above Decision is legally binding on the parties, subject only to an appeal to the High Court not later than 35 days after the date of notification of this Decision.

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FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

6 September 2019

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Pursuant to *Section 62* of the *Financial Services and Pensions Ombudsman Act 2017*, the Financial Services and Pensions Ombudsman will publish legally binding decisions in relation to complaints concerning financial service providers in such a manner that—

(a) ensures that—

(i) a complainant shall not be identified by name, address or otherwise,

(ii) a provider shall not be identified by name or address, and

(b) ensures compliance with the Data Protection Regulation and the Data Protection Act 2018.